211 CMR 112.00: WORKERS' COMPENSATION PREFERRED PROVIDER ARRANGEMENTS

Section

112.01: Authority

211 CMR 112.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by M.G.L. c. 176I, § 8(a) as enacted by St. 1988 c. 23, § 65 and by M.G.L. c. 152, § 30.

112.02: Definitions

As used in 211 CMR 112.00, the following words shall have the following meanings:

Applicant, a health maintenance organization as defined in M.G.L. c. 176G, a non-profit hospital service corporation authorized under M.G.L. c. 176A, a medical service corporation authorized under M.G.L. c. 176B, any incorporated or unincorporated group of health care providers or any other corporate entity engaged in the delivery or administration of the delivery of health services under workers' compensation or employee health benefit programs seeking approval of a workers' compensation preferred provider arrangement pursuant to 211 CMR 112.00. An insurer, self-insurer or group self-insurer seeking approval of such an arrangement may file an application on behalf of an applicant as herein defined.

Commissioner, the Commissioner of Insurance or his or her designee.

Covered person, an employee under the provisions of M.G.L. c. 152 who is subject to the terms of a preferred provider arrangement under M.G.L. c. 152, § 30.

Health care provider, a provider of health care services licensed or registered pursuant to M.G.L. c. 111 or 112.

Preferred provider, a health care providerwho has contracted with a preferred provider organization to provide specified health care services through a workers' compensation preferred provider arrangement.

Preferred provider arrangement, a contractual arrangement between an insurer, self-insurer, or self-insurance group, as defined in M.G.L. c. 152, §§ 1, 25A, or 25E, respectively, and a preferred provider organization to provide all or a specified portion of health care services resulting from workers' compensation claims by covered persons against such insurer, self-insurer or self-insurance group under the provisions of M.G.L. c. 152, § 30.

Preferred provider organization, an applicant which has contracted with preferred providers and an insurer, self-insurer or self-insurance group to provide specified services through a workers' compensation preferred provider arrangement which has been approved in accordance with 211 CMR 112.00.

112.03: Applicability

No preferred provider organization may enter into a preferred provider arrangement pursuant to the provisions of M.G.L. c. 152, § 30, without complying with the filing and other requirements set forth in 211 CMR 112.00.

112.04: Filing Requirements and Review by the Commissioner

(1) Application Filing Requirements. Each applicant shall submit the following required information in the order shown in 211 CMR 112.04(1)(a) through (m). The submitted documentation shall be considered the applicant's PPA application.

(a) A copy of the basic organizational documents of the applicant, such as the articles of incorporation, and amendments thereto;

(b) A copy of the bylaws, rules, regulations or other similar documents regulating the internal affairs of the applicant;

(c) A list of the names, business addresses and official positions of members of the board of directors or similar policymaking body of the applicant, and of persons who are responsible for the conduct of applicant's affairs;

(d) A list of the names and business addresses of every health care provider proposed to be included in the preferred provider organization, along with the provider type or medical specialty of each such provider;

(e) A list of each type of provider and medical specialty represented by the applicant and the number of individuals representing each such type of practice and specialty, along with the approximate total number of hours per week that the applicant will make available in such types of practice and specialties for the treatment of covered persons subject to the preferred provider arrangement;

(f) A general narrative description of the financial arrangements between the applicant and the insurer, self-insurer or self-insurance group that is a party to the proposed arrangement. This description need not include any specific details of the financial terms between the applicant and the insurer, self-insurer or self-insurance group, but must indicate, for example, if the arrangement is on a fee-for-service basis, or if volume discounts will be given;

(g) A general narrative description of the financial arrangements between the applicant and the health care providers proposed to be the preferred providers upon approval of the application. This description need not include any specific details of the financial arrangements between the applicant and such health care providers;

(h) A list of each insurer, self-insurer, and self-insurance group with which the applicant has previously entered into a workers' compensation preferred provider arrangement, and of each insurer, self-insurer, and self-insurance group with which the applicant has a pending application for a workers' compensation preferred provider arrangement;

(i) A written description and a map of the geographical areas proposed to be covered by the preferred provider arrangement and the locations of the main concentrations of covered persons subject to the arrangement;

(j) A description of the manner in which covered health care services and other benefits may be obtained by covered persons, including any requirement that covered persons select a gatekeeper provider;

(k) A copy of the information annually distributed to covered persons which shall include clear reference to the following facts:

1. that a covered person is required to obtain treatment within the preferred provider organization for the first scheduled appointment or incur the responsibility to pay for such appointment, provided that such person may seek health care service for a compensable injury outside the preferred provider organization for the initial scheduled appointment without incurring any financial obligation when such appointment is with a licensed or registered health care provider of a type or specialty not represented within the preferred provider organization;

2. that a covered person may seek health care service for a compensable injury outside the preferred provider organization after the initial scheduled appointment without incurring any obligation to pay for such subsequent visit according to the provisions of M.G.L. c. 152, § 30; and

3. that no co-payments or deductibles may be charged covered persons with compensable injuries who utilize the preferred provider organization or any other health care provider under the provisions of M.G.L. c. 152, §§ 13 and 30;

(l) A description of:

1. the Department of Industrial Accidents (DIA) approved utilization review and quality assessment program along with a copy of the DIA's letter of current authorization for said program;

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2. the Return to Work program that will be used by the applicant; and

3. the applicant's written agreement to abide by any treatment guidelines or protocols promulgated by the DIA pursuant to M.G.L. c. 152, §§ 13 and 30; and

(m) A statement from the insurer, self-insurer or self-insurance group that is a party to the preferred provider arrangement asserting that:

1. each employer whose employees would be covered persons under the arrangement has given written consent to such arrangement;

2. that to the best of the knowledge of the insurer, self-insurer or self-insurance group the arrangement is not inconsistent with any collective bargaining agreement affecting any covered person under the arrangement; and

3. that said written consent form of each insured and said collective bargaining agreements covering each insured are in the possession of the insurer, self-insurer or self-insurance group and will be made available to the Commissioner upon request. Each self-insurer and self insurance group must submit a copy of its current authorization to act as a self-insurer or self insurance group.

(2) Additional Material. After reviewing the application, if the Commissioner finds the filing incomplete, he or she shall give the applicant notice to that effect and shall specify the additional documents or information deemed necessary to complete the review. The applicant shall file the additional material required within 30 days of its receipt of the notice, or shall request an extension in writing within that time. Extensions of up to 60 days may be granted by the Commissioner for submission of additional material. A copy of all materials filed with the Division of Insurance on behalf of an applicant must be filed with the Department of Industrial Accidents.

(3) Duty to Seek Licensure. If in the review of the material submitted by an applicant, the Commissioner determines that such applicant is in fact engaging or proposing to engage in the business of insurance as defined in M.G.L. c. 175; or the business of a nonprofit hospital service corporation as defined in M.G.L. c. 176A; or the business of a medical service corporation as defined in M.G.L. c. 176B; or the business of a dental service corporation as defined in M.G.L. c. 176E; or the business of an optometric service corporation as defined in M.G.L. c. 176F; or the business of a health maintenance organization as defined in M.G.L. c. 176G, the Commissioner will so inform the organization and require it to seek licensure under the appropriate statute. The Commissioner may require the organization to submit any information necessary to make this determination.

112.05: Standards of Review by the Commissioner

Upon receipt of a complete application for approval of a workers' compensation preferred provider arrangement the Commissioner will review the submitted material to determine that the following standards are met:

(a) The preferred provider arrangement makes available a sufficient number and range of providers by specialty and geographic area to provide covered persons with industrial accidents or diseases, timely access to and availability of preferred providers for emergency care, urgent care and elective care;

(b) A procedure exists for distributing to each covered person, after any alleged workplace injury to such person, the names of all current preferred providers within the geographic region of such covered person or of all current preferred providers arranged geographically. The names on such list shall be arranged in order of medical specialty or provider type. A current list shall also be posted at a convenient and prominent place for covered persons to examine at worksites, and shall be given to any covered person upon request. In addition, a document clearly setting forth the rights and responsibilities of covered persons under the preferred provider arrangement and under M.G.L. c. 152, §§ 13 and 30, including the right to take complaints regarding the provision of health care services to the Health Care Services Board, shall be distributed to covered persons upon initial approval of the preferred provider arrangement and annually thereafter, posted in a prominent place in workplaces where covered workers are employed, and given to any covered person alleging to have suffered a workplace injury. Such information shall indicate the method of obtaining a current list of preferred providers;

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(c) Each preferred provider is given a clear description of the rights of covered persons and the obligations of the applicant to covered persons; and

(d) There is a DIA approved utilization review and quality assessment program (UR & QA) in place to ensure appropriate and efficient provision of high quality health services. Said program shall incorporate any protocols or treatment guidelines promulgated by the DIA pursuant to M.G.L. c. 152, §§ 13 and 30. Any restrictions or requirements imposed on covered persons by the UR & QA program must be adequately explained in the materials annually distributed to covered persons. There must be procedures to guarantee cooperation by preferred providers with the UR & QA program which allow for the removal of noncomplying providers from the arrangement. There must be a procedure for referring covered persons to health care services outside the preferred provider organization when indicated by diagnosis, excessive travel time, and presence of any pre-existing medical condition which would make treatment substantially more difficult.

(e) The PPA application must contain a position statement indicating how the applicant intends to facilitate the return to work of injured employees in a rapid, cost-effective and safe manner.

112.06: Approval or Disapproval of Application

The Commissioner shall review any application in accordance with the criteria set forth in 211 CMR 112.04(1) and shall determine whether approval shall be granted or denied. If approval of the application is granted, a copy of the approved application must then be forwarded to the Office of Health Policy at the Department of Industrial Accidents located at 600 Washington Street, Boston, MA 02111. If an application is denied, the Commissioner shall notify the applicant in writing of the reason(s) for the denial. The applicant shall have the right to a hearing on its application within 45 days of its receipt of such notice by filing a written request for hearing within 15 days of its receipt of such notice. Within 30 days after the conclusion of the hearing, the Commissioner shall either grant approval or shall notify the applicant in writing of the denial of its application, stating the reason(s) for the denial. The applicant shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, § 14.

112.07: Ongoing Review of Preferred Provider Arrangements

(1) Material Changes. Each preferred provider organization shall file with the Commissioner within 30 days any material changes to the approved preferred provider arrangement or the information submitted pursuant to 211 CMR 112.00. Any substantial change in the number, type or geographical location of covered persons shall be reported on or before July 30 of each year.

(2) Changes to the List of Preferred Providers. Each preferred provider organization shall file changes to its list of preferred providers with the Commissioner on or before July 30 of each year.

(3) Additional Reports. The Commissioner, in his or her discretion, may require preferred provider organizations to submit reports in addition to those specifically required by 211 CMR 112.00. Such reports may include surveys of covered persons conducted in a method prescribed by the Commissioner.

112.08: Cease and Desist Orders

(1) The Commissioner may issue an order requiring any person, organization or insurer to cease and desist from violating any provision of M.G.L. c. 176I, 211 CMR 112.00, or any rules or orders hereunder. Before the Commissioner issues a cease and desist order to any person, organization or insurer, he or she shall issue and serve upon such person, organization or insurer a statement of the charges and notice of a hearing thereon to be held at a time and place fixed in the notice, which shall be not less than 21 days after the date of the service thereof. The hearing shall be conducted in accordance with the adjudication procedures set forth in M.G.L. c. 30A.

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(2) If the Commissioner makes written findings of fact that the public interest will be irreparably harmed by delay in issuing an order in accordance with 211 CMR 112.08(1), he or she may issue a temporary cease and desist order. Upon the entry of a temporary cease and desist order, the Commissioner shall promptly notify in writing the person subject to the order that such order has been entered, the reasons therefore, and that within 21 days after the receipt of a written request from such person the matter shall be scheduled for hearing to determine whether or not the order shall become permanent and final. If no hearing is requested and none is ordered by the Commissioner, the order shall remain in effect until it is modified or vacated by the Commissioner. If a hearing is requested or ordered, the Commissioner shall, after such hearing, make written findings of fact and conclusions of law and shall vacate, modify or make permanent the order.

112.09: Fines

The Commissioner may require any person, organization or insurer found to have violated any provision of M.G.L. c. 176I, 211 CMR 112.00 or any rule or order hereunder to pay a fine not to exceed $10,000 for any single violation.

REGULATORY AUTHORITY

211 CMR 112.00: M.G.L. c. 176I, § 8(a).

NON-TEXT PAGE